

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11746
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11746
Reg. Dist.

No. 51

1. PLACE OF DEATH: COUNTY <u>Calvert</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Hamlet</u> TOWN <u>Hamlet</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Calvert</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Hamlet</u> OR TOWN <u>Hamlet</u> STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) (First) <u>Frank</u> (Middle) <u>L</u> (Last) <u>Brown</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>16</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>		8. DATE OF BIRTH: <u>June 26 '86</u>	
9. AGE last birthday: <u>69</u> yrs.				10. IF UNDER 1 YEAR: Months <u> </u> Days <u> </u>		11. IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Common Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u> </u>		11. BIRTHPLACE (State or foreign country): <u>MD</u>	
12. CITIZEN OF WHAT COUNTRY? <u>US</u>				13. FATHER'S NAME: <u>McHenry Brown</u>			
14. MOTHER'S MAIDEN NAME: <u>Fannie Rawling</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: <u>20-28-4563</u>				17. INFORMANT & ADDRESS: <u>Mrs. Edith Brown</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>420.1</u> Immediate cause (a) <u>Cerebral aneurysm</u> DUE TO Antecedent cause(s) (b) <u> </u> Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u> </u> DUE TO						INTERVAL BETWEEN ONSET AND DEATH	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Found dead in bed</u>							
19a. DATE OF OPERATION: <u> </u>				19b. MAJOR FINDING OF OPERATION: <u> </u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>				21. PLACE (Home, farm, factory, office, etc.) <u>Hamlet Calvert MD</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. CITY OR TOWN (County) (State) <u>Hamlet Calvert MD</u>			
21c. TIME (Month) (Day) (Year) (Hour) OF INJURY <u> </u> M. <u> </u>				21d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
21e. HOW DID INJURY OCCUR? <u> </u>							
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> SIGNATURE <u>H. W. Ward</u> CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>12/16/55</u> M. D. DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <u> </u>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>				DATE THEREOF <u>Dec. 18, 1955</u>			
NAME OF CEMETERY OR CREMATORY <u>Wesley Cemetery</u>				LOCATION (City, town, or county) (State) <u>Prince Frederick, MD</u>			
DATE REC'D BY LOCAL REG <u>12/17/55</u>				REGISTRAR'S SIGNATURE <u>H. W. Ward</u>			
24. FUNERAL DIRECTOR <u>A. G. Hackmeyer & Son - Mutual, Ind.</u>				ADDRESS <u> </u>			

RECEIVED

DEC 20 1955

BUREAU V. S.

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11747

11747 **CERTIFICATE OF DEATH**

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Cabaret</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Cabaret</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Huntingtown</u>		LENGTH OF STAY (In this place) <u>Life</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Huntingtown</u>		STREET ADDRESS (If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>							
3. NAME OF DECEASED (First) (Middle) (Last) <u>ay. Kent Bowie</u>				4. DATE OF DEATH (Month) (Day) (Year) <u>Dec. 22, 1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>D</u>	8. DATE OF BIRTH <u>Feb. 22, 1877</u>		9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months <u>10</u> Days <u>0</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm Nurse</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>		11. BIRTHPLACE (State or foreign country) <u>Mt. Zion A.A. Co Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Edmund L. Bowie</u>				14. MOTHER'S MAIDEN NAME <u>Violetta Belt</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>no</u>		17. INFORMANT & ADDRESS <u>E. Lansdale Bowie, Luthany Md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <u>163X IMMEDIATE CAUSE (A) Carcinoma of Lung.</u>							
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (B) _____							
(C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>12/22</u>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/22</u> , 19 <u>53</u> , to <u>12/22</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>12/22</u> , 19 <u>55</u> , and that death occurred at _____ M., from the causes and on the date stated above.							
SIGNATURE <u>E. J. Weese</u>				ADDRESS (Street, city, town, state) <u>Huntingtown Md</u>		DATE SIGNED <u>12/23/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>Dec. 24, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>All Saints' Cem</u>		LOCATION (City, town, or county) (State) <u>Huntingtown, Md.</u>	
24. REC'D BY REGISTRAR <u>12-24-55</u>		REGISTRAR'S SIGNATURE <u>H. W. Ward</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>A. A. Harpless - Mutual, Md.</u>			

1444

BY JOSEPH STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

1444 CERTIFICATE OF DEATH

THE DATE OF

1. NAME OF DECEASED (Last, first, middle)

2. SEX

3. AGE

4. OCCUPATION

5. PLACE OF BIRTH

6. DATE OF DEATH

7. TIME OF DEATH

8. CAUSE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESS

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CLERK

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

16. SIGNATURE OF CORONER

17. SIGNATURE OF JURY

18. SIGNATURE OF COURT

19. SIGNATURE OF STATE

20. SIGNATURE OF FEDERAL

21. SIGNATURE OF LOCAL

22. SIGNATURE OF COUNTY

23. SIGNATURE OF CITY

24. SIGNATURE OF TOWNSHIP

25. SIGNATURE OF VILLAGE

26. SIGNATURE OF BOROUGH

27. SIGNATURE OF PARISH

28. SIGNATURE OF PRESTBYTERY

29. SIGNATURE OF SYNAGOGUE

30. SIGNATURE OF CHURCH

31. SIGNATURE OF TEMPLE

32. SIGNATURE OF MOSQUE

33. SIGNATURE OF GURDWARA

34. SIGNATURE OF DARGA

35. SIGNATURE OF MONASTERY

36. SIGNATURE OF CONVENT

37. SIGNATURE OF NUNNERY

38. SIGNATURE OF PRIORY

39. SIGNATURE OF ABBEY

40. SIGNATURE OF CATHEDRAL

41. SIGNATURE OF CHAPEL

42. SIGNATURE OF ALTAR

43. SIGNATURE OF PULPIT

44. SIGNATURE OF TABERNACLE

45. SIGNATURE OF SACRISTY

46. SIGNATURE OF CHANCEL

47. SIGNATURE OF AISLE

48. SIGNATURE OF NAVE

49. SIGNATURE OF TRANSEPT

50. SIGNATURE OF CHURCHYARD

51. SIGNATURE OF CEMETERY

52. SIGNATURE OF BURIAL

53. SIGNATURE OF INTERMENT

54. SIGNATURE OF CREMATION

55. SIGNATURE OF URN

56. SIGNATURE OF COFFIN

57. SIGNATURE OF CASK

58. SIGNATURE OF BOX

59. SIGNATURE OF CASE

60. SIGNATURE OF CHEST

61. SIGNATURE OF CUPBOARD

62. SIGNATURE OF HURDLE

63. SIGNATURE OF BENCH

64. SIGNATURE OF PIEDestal

65. SIGNATURE OF MONUMENT

66. SIGNATURE OF GRAVE

67. SIGNATURE OF TOMB

68. SIGNATURE OF SEPULCHRE

69. SIGNATURE OF EXHIBIT

70. SIGNATURE OF SPECIMEN

71. SIGNATURE OF EVIDENCE

72. SIGNATURE OF PROOF

73. SIGNATURE OF TESTIMONY

74. SIGNATURE OF VERIFICATION

75. SIGNATURE OF CORROBORATION

76. SIGNATURE OF SUBSTANTIATION

77. SIGNATURE OF CONFIRMATION

78. SIGNATURE OF VALIDATION

79. SIGNATURE OF AUTHENTICATION

80. SIGNATURE OF RATIFICATION

81. SIGNATURE OF SANCTION

82. SIGNATURE OF APPROVAL

83. SIGNATURE OF ENDORSEMENT

84. SIGNATURE OF COUNTERSIGNATURE

85. SIGNATURE OF CO-SIGNATURE

86. SIGNATURE OF JOINT SIGNATURE

87. SIGNATURE OF COLLECTIVE SIGNATURE

88. SIGNATURE OF REPRESENTATIVE SIGNATURE

89. SIGNATURE OF AUTHORIZED SIGNATURE

90. SIGNATURE OF DELEGATED SIGNATURE

91. SIGNATURE OF APPOINTED SIGNATURE

92. SIGNATURE OF COMMISSIONED SIGNATURE

93. SIGNATURE OF EMPLOYED SIGNATURE

94. SIGNATURE OF ASSIGNED SIGNATURE

95. SIGNATURE OF DESIGNATED SIGNATURE

96. SIGNATURE OF NAMED SIGNATURE

97. SIGNATURE OF IDENTIFIED SIGNATURE

98. SIGNATURE OF RECOGNIZED SIGNATURE

99. SIGNATURE OF KNOWN SIGNATURE

100. SIGNATURE OF FAMILIAR SIGNATURE

101. SIGNATURE OF IDENTICAL SIGNATURE

102. SIGNATURE OF EQUIVOCAL SIGNATURE

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11748

11748 **CERTIFICATE OF DEATH**

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <i>Calvert</i>		MARYLAND		STATE <i>Md</i>		COUNTY <i>Calvert</i>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
X TOWN <i>Prince Federal</i>		<i>14 hrs</i>		TOWN <i>Sunderland</i>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert Co #</i>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <i>Virginia</i> (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year) <i>12 24 1955</i>			
5. SEX <i>F</i>	6. COLOR OR RACE <i>C</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>S</i>	8. DATE OF BIRTH <i>July 30, 1937</i>	9. AGE last birthday <i>4</i> yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
					Months	Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Free school</i>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <i>Md</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Wm Virginia</i>				14. MOTHER'S MAIDEN NAME <i>Helen Creek</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <i>Mother</i>			
18. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				19. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
<i>916.0 IMMEDIATE CAUSE (A) Shock due to first, second</i>				<i>Third degree burn 7 days</i>		<i>14 hrs</i>	
<i>ANTECEDENT CAUSE(S) DUE TO</i>				<i>burn injuries to face & arms</i>			
<i>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO</i>				<i>There was not a fine by old child</i>			
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
<i>12/23/55 7 P M.</i>		<i>Home</i>		<i>Home</i>			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<i>12/23/55 7 P M.</i>		<i>While at work</i>		<i>Old child at fireplace</i>		<i>04</i>	
22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at....., from the causes and on the date stated above.							
SIGNATURE <i>H W Ward M.D.</i>				DATE SIGNED <i>12/24/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county)	
<i>12-24-55</i>				<i>Way of the Cross</i>		<i>Sunderland</i>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<i>DATE 12-28-55</i>		<i>H. W. Ward</i>		<i>P. E. Sawell</i>		<i>Prince Frederick Md</i>	

1114

MASSACHUSETTS DEPARTMENT OF HEALTH-BELTIMORE, MD

CERTIFICATE OF DEATH

Form No. 100

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Manner of death

8. Signature of physician

9. Signature of registrar

10. Signature of informant

11. Signature of funeral director

12. Signature of coroner

13. Signature of justice of the peace

14. Signature of health officer

15. Signature of registrar

16. Signature of informant

17. Signature of funeral director

18. Signature of coroner

19. Signature of justice of the peace

20. Signature of health officer

21. Signature of registrar

22. Signature of informant

23. Signature of funeral director

24. Signature of coroner

25. Signature of justice of the peace

26. Signature of health officer

27. Signature of registrar

28. Signature of informant

29. Signature of funeral director

30. Signature of coroner

31. Signature of justice of the peace

32. Signature of health officer

33. Signature of registrar

34. Signature of informant

35. Signature of funeral director

36. Signature of coroner

37. Signature of justice of the peace

38. Signature of health officer

39. Signature of registrar

40. Signature of informant

41. Signature of funeral director

42. Signature of coroner

43. Signature of justice of the peace

44. Signature of health officer

45. Signature of registrar

46. Signature of informant

47. Signature of funeral director

48. Signature of coroner

49. Signature of justice of the peace

50. Signature of health officer

49. Signature of registrar

50. Signature of informant

51. Signature of funeral director

50. Signature of coroner

51. Signature of justice of the peace

52. Signature of health officer

51. Signature of registrar

52. Signature of informant

53. Signature of funeral director

52. Signature of coroner

53. Signature of justice of the peace

54. Signature of health officer

53. Signature of registrar

54. Signature of informant

55. Signature of funeral director

54. Signature of coroner

55. Signature of justice of the peace

56. Signature of health officer

55. Signature of registrar

56. Signature of informant

57. Signature of funeral director

56. Signature of coroner

57. Signature of justice of the peace

58. Signature of health officer

BUREAU V. S.

DEC 29 1925

RECEIVED

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

V5 A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11749

11749

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>CALVERT</u>		STATE <u>MARYLAND</u>		COUNTY <u>CALVERT</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>PRINCE FREDERICK</u>		<u>1 HOUR</u>		TOWN <u>MUTUAL</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>CALVERT COUNTY HOSPITAL</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print) <u>WARREN GANTT</u>				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>11</u> (Year) <u>55</u>			
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>COLORED</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>10-22-1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR (Months) <u>12</u> (Days) <u>11</u>		IF UNDER 24 HRS. (Hours) <u>55</u> (Min.) <u>19</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Calvert County, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOHN W. GANTT</u>				14. MOTHER'S MAIDEN NAME <u>CAROLINE WHITE</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>MRS. CHARLOTTE GANTT, MUTUAL, MD.</u>			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
<u>420.1</u> IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>-</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>-</u>							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>12/11/55</u> , to <u>12/11/55</u> , that I last saw the deceased alive on <u>12/11/55</u> , and that death occurred at <u>3:40</u> M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u> M.D. <u>St. Roman</u>				DATE SIGNED <u>12/11/55</u>			
23. (BURIAL, CREMATION, REMOVAL) (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>12-14-55</u>		<u>Brooks Chapel</u>		<u>Island Creek Md</u>			
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE			
DATE <u>12-12-55</u>		<u>Dr. H. W. Ward</u>		<u>P. E. Sewell, Prince Fred. Md.</u>			

CERTIFICATE OF DEATH

ILLINOIS STATE DEPARTMENT OF HEALTH - SPRINGFIELD

1955

PRODUCED BY

ILLINOIS STATE DEPARTMENT OF HEALTH - SPRINGFIELD
This certificate is a record of the death of the person named above and is not a legal document. It is to be used for statistical purposes only. It is not to be used for legal purposes. It is not to be used for insurance purposes. It is not to be used for any other purpose.

BUREAU V. S.

DEC 14 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11750
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11750
 Reg. Dist.

No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY Calvert		MARYLAND		STATE Md.		COUNTY Calvert	
CITY (If outside corporate limits, write RURAL or and give nearest town) TOWN Prince Frederick				CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Prince Frederick			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED: (Type or Print)		(First) GEORGE		(Middle) BROOK		(Last) DORSEY GRAY	
4. DATE OF DEATH		(Month) 12/27		(Day)		(Year) 1955	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR Months Days Hours Min.		
Male	White	Married		60	60 yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of work life; even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<i>Admission Clerk Assistant</i>		<i>Biological Lab</i>		<i>Calvert Co., Md</i>		<i>U.S.A.</i>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<i>John B. Gray</i>				<i>Katie L. Dorsey</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<i>No</i>		<i>No</i>		<i>Yvonne Gray - Prince Frederick, Md</i>			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:						INTERVAL BETWEEN ONSET AND DEATH	
Immediate cause (a) Gunshot wound of brain DUE TO Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:					
<i>2</i>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY)		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
		<i>Home</i>		<i>Calvert Md.</i>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<i>12/27/55 3:30 PM.</i>				<i>Shot self in head</i>			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>R. F. Fisher</i>		<i>Dec. 30, 1955</i>		<i>St. Paul's Cemetery</i>		<i>Prince Frederick, Md</i>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR ADDRESS	
<i>Burial</i>		<i>12-29-55</i>		<i>H. H. Hard</i>		<i>A. A. Wackerus - Hon. Mutual, Md.</i>	

BUREAU V. S.

JAN 2 1966

RECEIVED

11751

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11751

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 51

1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND CITY (If outside corporate limits, write RURAL and give nearest town) <u>Winton</u> TOWN <u>Winton</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Calvert</u> CITY (If outside corporate limits write RURAL and give nearest town) <u>Winton</u> TOWN <u>Winton</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print) <u>Engene Orlando Johnson</u>		4. DATE OF DEATH <u>12 22 55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED:	8. DATE OF BIRTH: <u>Jan 23, 1882</u>
9. AGE last birthday: <u>73</u> yrs.		10. IF UNDER 1 YEAR: Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>MD</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Benj. Johnson</u>		14. MOTHER'S MAIDEN NAME: <u>Julia Hallam</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>No</u>		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <u>Chaplin Johnson, Winton, MD</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: Immediate cause (a) <u>Fractured skull & broken neck</u> DUE TO Antecedent cause(s) (b) <u>Force ran away</u> DUE TO Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)			INTERVAL BETWEEN ONSET AND DEATH
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Home</u>	21c. City or town (County) (State): <u>Winton Calvert MD</u>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>M.</u>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: <u>H. W. Ward</u>		CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/> DATE SIGNED: <u>12/24/55</u> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):	DATE THEREOF: <u>12-26-55</u>	NAME OF CEMETERY OR CREMATORY: <u>Island Creek</u>	LOCATION (City, town, or county) (State): <u>Winton MD</u>
DATE REC'D BY LOCAL REG. <u>12-3-55</u>	REGISTRAR'S SIGNATURE: <u>H. W. Ward</u>	24. FUNERAL DIRECTOR: <u>P. S. Seewell</u> ADDRESS: <u>Prince Frederick</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Figure 6

11752 CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Wash. D.C.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR	
TOWN <u>Prince Frederick</u>		<u>22 hrs. 4 min.</u>		TOWN <u>Washington D.C.</u>		(If rural give location)	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert Co. Hospital</u>				STREET ADDRESS <u>1364 Randolph St. N.W.</u> ✓			
3. NAME OF DECEASED (Type or Print) <u>William</u> (First) <u>B.</u> (Middle) <u>hanigan</u> (Last)				4. DATE OF DEATH (Month) <u>12</u> (Day) <u>25</u> (Year) <u>1955</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M</u>	8. DATE OF BIRTH <u>June 21, 1892</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months <u>6</u> Days <u>4</u>		IF UNDER 24 HRS. Hours <u>4</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William F. Hanigan</u>				14. MOTHER'S MARDEN NAME <u>Margaret Jacques</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Hospital Records</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
331X IMMEDIATE CAUSE (A) <u>Cerebral Hemorrhage</u>							
ANTECEDENT CAUSE(S) DUE TO (B) <u>arterio-sclerosis (Hypertension)</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M.		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Dec 25, 1955</u> to <u>Dec 25, 1955</u> , that I last saw the deceased alive on <u>Dec 25, 1955</u> , and that death occurred at <u>3:45</u> P.M. from the causes and on the date stated above.							
SIGNATURE <u>Robert O. Humphrey</u> M.D.				ADDRESS (Street, city, town, state) <u>St Leonard Washington D.C.</u> DATE SIGNED <u>Dec 25/55</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>12/29/55</u>		NAME OF CEMETERY OR CREMATORY <u>St. Elizabeth's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Washington D.C.</u>	
24. REC'D BY REGISTRAR <u>H. W. Ward</u>		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE <u>Robert O. Humphrey</u>		ADDRESS <u>Bethesda</u>	
DATE <u>12-28-55</u>							

INSTRUCTIONS

1. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. All this information has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

2. TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. All this information has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

3. TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be filed with the registrar within 72 hours after death. All this information has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

U.S. AIR FORCE

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11753

11753 CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Calvert County</u>		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>			
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>North Beach</u>		<u>4 hrs.</u>		TOWN			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location) <u>Prince Frederick, Maryland</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>William</u> (Middle) <u>Oscar</u> (Last) <u>Marshall</u>				(Month) <u>Dec.</u> (Day) <u>20</u> (Year) <u>1955</u>			
5. SEX		6. COLOR OR RACE		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)		8. DATE OF BIRTH	
<u>Male</u>		<u>White</u>		<u>Wid.</u>		<u>July 19, 1875</u>	
						9. AGE last birthday	
						<u>80</u> yrs.	
						# UNDER 1 YEAR	
						Months Days	
						# UNDER 24 HRS.	
						Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
<u>Manager</u>				<u>Restaurant</u>		<u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY?				<u>U.S.</u>			
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME			
<u>Samuel Wm. Marshall</u>				<u>Evans</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<u>unk.</u>						<u>Miss Maria Marshall - North Beach, Md.</u>	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>acute Pulmonary Edema</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 hours</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arterio sclerotic C.V. Disease</u>						<u>2 years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)				21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>1957</u> , to <u>Dec 20</u> , 1955 , that I last saw the deceased alive on <u>Dec 20</u> , 1955 , and that death occurred at <u>M.</u> , from the causes and on the date stated above.							
SIGNATURE <u>Page J. H.</u>				ADDRESS (Street, city, town, state) <u>Prince Frederick</u>		DATE SIGNED <u>12/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)				DATE THEREOF		NAME OF CEMETERY OR CREMATORY	
<u>Cedar Hill Cem.</u>				<u>12/23/55</u>		<u>Cedar Hill Cemetery</u>	
24. REC'D BY REGISTRAR				REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE	
<u>DEC 20 1955</u>				<u>Chas B. Cox</u>		<u>J. H. Harris & Son Co.</u>	
DATE				ADDRESS		<u>300 4th St. NE</u>	
						<u>Lee Funeral Home</u>	

1173 CERTIFICATE OF DEATH

INSTRUCTIONS

1. This form is to be filled out by the attending physician or the coroner. It should be filled out as soon as possible after death. It is to be filed in the office of the Registrar of Vital Statistics, State Department of Health, Boston, Massachusetts.

Dr. J. H. McQuinn
100 State Street, Boston, Mass.

BUREAU V. B.

DEC 28 1955

RECEIVED

11754

11754

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 51

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>Maryland</u> COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Island Creek</u>		TOWN <u>Adelina Md.</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <u>John</u>	(Middle) <u>Thomas</u>	(Last) <u>Willet</u>	(Month) <u>12</u> (Day) <u>25</u> (Year) <u>1955</u>
5. SEX: <u>M.</u>	6. COLOR OR RACE: <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH: <u>Jan 21</u>
9. AGE last birthday: <u>18</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farm Labor</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>P</u>		14. MOTHER'S MAIDEN NAME: <u>Florence Willett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.: <u>217-32-3002</u>	
17. INFORMANT & ADDRESS: <u>Florence Willett, Adelina Md.</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
(a) Immediate cause: <u>Gunshot wound (Shotgun) of Left Chest</u>			
(b) Antecedent cause(s): <u>Massive Thoracic Hemorrhage</u>			
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last: <u>Skull Fracture</u>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>2</u>		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY: <u>Island Creek - Calvert - Md</u>	
21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY: <u>12-25-55</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: <u>William Updegraff</u>		M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>	
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF: <u>12-29-55</u>	
NAME OF CEMETERY OR CREMATORY: <u>Carroll's</u>		LOCATION (City, town, or county): <u>Barstow</u>	
DATE REC'D BY LOCAL REG. <u>12-29-55</u>		24. FUNERAL DIRECTOR: <u>P.F. Sewell Prince Frederick Md</u>	
REGISTRAR'S SIGNATURE: <u>R.W. Ward</u>		ADDRESS: <u>me</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JAN 2 1966

RECEIVED